
Legislative Briefing: Patient Rights and Responsibilities Laws

Background

In 1998, the Governor signed into law ACT 178 which establishes the Hawaii Patient Bill of Rights and Responsibilities Act. This law is the first step toward insuring that patients are afforded rights and protections in the evolving health care industry. ACT 178 created a task force chaired by the Insurance Commissioner to monitor implementation of the law and to draft additional legislation to strengthen the original bill. HMA is a member of the task force along with individuals representing consumers, hospitals, health plans, and government. This past legislative session, a second bill was drafted by the task force to build upon the original Patient Bill of Rights and Responsibilities Act. The bill passed and was signed into law (ACT 137) on June 25, 1999.

The purpose of this document is to provide you with a summary of the provisions of the two patients' rights and responsibilities laws. *This document is intended as an informational guide only and not as legal advice.* For a complete copy of the law or for additional information, please contact Heidi Singh, Director of Legislative/Gov't Affairs, at 536-7702, ext. 2241 or hysingh@juno.com.

[NOTE: The definition of managed care plan in the laws is drafted to apply to all health plans. The term "commissioner" refers to the insurance commissioner]

Access to services

A managed care plan shall demonstrate to the commissioner upon request that its plan:

- 1) Makes benefits available and accessible to each enrollee electing the managed care plan in the defined service area with reasonable promptness and in a manner which promotes continuity in the provision of health care services;
- 2) Provides access to sufficient numbers and types of providers to ensure that all covered services will be accessible without reasonable delay;
- 3) When medically necessary, provides health care services 24-hours a day/7-days a week; (NOTE: The task force has recently been directed by the Legislature to develop a definition of "medically necessary")
- 4) Provides a reasonable choice of qualified providers of women's health services such as gynecologists, obstetricians, certified nurse-midwives, and advanced practice nurses to provide preventive and routine women's health care services;

5) Provides payment or reimbursement for adequately documented emergency services

6) Allows standing referrals to specialists capable of providing and coordinating primary and specialty care for an enrollee's life-threatening, chronic, degenerative, or disabling disease or condition.

Emergency care

A health plan shall reimburse an emergency provider and an emergency department for any items or services not necessary to stabilize the patient under at least one of the following:

- 1) The items or services are determined to be medically necessary to treat the illness that led the patient to believe that he had an emergency medical condition, and that a reasonable patient would expect to receive such items or services from a physician at the time of presentation; or
- 2) The items or services are determined to be medically necessary by the emergency provider, if the emergency department:
 - (A) After a documented good faith effort, is unable to reach the enrollee's health plan:
 - (i) Within thirty minutes from the initial examination of the enrollee; or
 - (ii) If the enrollee needs to be stabilized, within thirty minutes of stabilization;
 - (B) Has successfully contacted the plan as required in subparagraph (A), and has not received a denial from the plan within thirty minutes of the initial contact, unless the plan is able to document that it has made an unsuccessful good faith effort to reach the ER department within 30 minutes after receiving the request for authorization; or
 - (C) Has successfully contacted the plan and has received a denial from a person other than a participating physician and:
 - (i) A participating physician authorized by the plan to review denials reverses the denial; or
 - (ii) A participating physician authorized by the plan to review denials fails to communicate a determination affirming the denial, (unless the treating physician waives the requirement for such determination), within 30 minutes after the initial denial is communicated by the plan.

A health plan shall immediately arrange for an alternate plan of treatment for the member if a non-participating emergency provider and the plan are unable to reach agreement on services necessary beyond those immediately needed to stabilize the member, under which:

- (A) A participating physician with privileges at the hospital arrives at the emergency department of the hospital promptly and assumes responsibility for the treatment of the member; or
- (B) With the agreement of the treating physician or another health professional in the emergency department:
 - (i) Arrangement is made for transfer of the member to another facility using medical resources consistent with the condition of the enrollee;
 - (ii) An appointment is made with a participating physician or provider for treatment needed by the enrollee; or
 - (iii) Another arrangement is made for treatment of the enrollee.

Enrollee participation in treatment decisions

An enrollee shall have the right to be informed fully prior to making any decisions about treatment, benefit, or non-treatment. In order to inform enrollees fully, the provider shall:

- 1) Discuss all treatment options with an enrollee and include the option of no treatment at all;
- 2) Ensure that persons with disabilities have an effective means of communication with the provider and other members of the managed care plan; and
- 3) Discuss all risks, benefits, and consequences to treatment and non-treatment; and
- 4) Discuss with the enrollee and the enrollee's immediate family both living wills and durable powers of attorney in relation to medical treatment.

[NOTE: The HMA has concerns with the vague nature of this section and is working through the legislative process to have the informed consent law clarified.]

Ban on Physician "Gag Orders:"

A plan is prohibited from imposing any type of prohibition, disincentive, penalty, or other negative treatment upon a provider for discussing or providing any information regarding treatment options and medically necessary or appropriate care, including no treatment, even if the information relates to services or benefits not provided by the plan.

Complaints and appeals procedure for enrollees *Plan's Internal Appeals Procedures*

- 1) All plans shall establish and maintain a procedure to provide for the resolution of enrollees' complaints and appeals. The procedures shall be reasonably understandable to the average layperson

and shall be provided in languages other than English upon request.

- 2) A plan shall send notice of its final internal determination to the enrollee, the enrollee's appointed representative, if applicable, and the commissioner.

External Appeals Procedures

After exhausting a plan's internal complaint and appeal process, an enrollee, or the enrollee's treating provider or appointed representative, may appeal an adverse decision of a plan to a three-member review panel appointed by the commissioner. The panel is to be composed of a representative from a health plan not involved in the complaint, a provider licensed to practice and practicing medicine in Hawaii not involved in the complaint, and the commissioner or the commissioner's designee.

- 1) The enrollee shall submit a request for review to the commissioner within 30 days from the date of the final determination by the plan;
- 2) Upon receipt of the request and upon a showing of good cause, the commissioner shall appoint the members of the panel. If the amount in controversy is less than \$500, the commissioner may conduct a review hearing without appointing a review panel;
- 3) The review hearing shall be conducted as soon as practicable, taking into consideration the medical exigencies of the cases, provided that the hearing shall be held no later than sixty days from the date of the request for the hearing;
- 4) The commissioner may retain an independent medical expert trained in the field of medicine most appropriately related to the matter under review;
- 5) After considering the enrollee's complaint, the plan's response, and any affidavits filed by the parties, the commissioner may dismiss the appeal if it is determined that the appeal is frivolous or without merit;
- 6) The review panel shall review every adverse determination to determine whether or not the plan involved acted reasonably and with sound medical judgment. The review panel shall consider the clinical standards of the plan, the information provided, the attending physician's recommendation, and generally accepted practice guidelines;
- 7) The commissioner, upon a majority vote of the panel, shall issue an order affirming, modifying or reversing the decision within thirty days of the hearing;
- 8) Members of the review panel shall be granted immunity from liability and damages relating to their duties on the panel.

Information to enrollees

A managed care plan shall provide to its enrollees upon enrollment and thereafter upon request the following information:

- 1) A list of participating providers which shall be updated on a regular basis indicating, at a minimum, their specialty and whether the provider is accepting new patients;
- 2) A complete description of benefits, services, and copayments;
- 3) A statement on an enrollee's rights, responsibilities, and obligations;
- 4) An explanation of the referral process, if any;
- 5) Where services or benefits may be obtained;
- 6) Information on the plan's complaints and appeals procedures;

Every managed care plan shall provide to the commissioner and its enrollees notice of any material change in participating provider agreements, services or benefits, if the change affects the organization or operation of the managed care plan and the enrollee's services or benefits. The plan shall provide notice to enrollees not more than sixty days after the change in a form that makes the notice clear and conspicuous so that it is readily noticeable by the enrollee. A plan shall provide generic participating provider contracts to enrollees, upon request.

Utilization review

Every plan shall establish procedures for continuous review of quality of care, performance of providers, utilization of health services, facilities, and costs.

Managed care plan performance measurement and data reporting standards

All managed care plans shall adopt and comply with nationally developed and promulgated standards for measuring quality, outcomes, access, satisfaction, and utilization of services. Every contract between a managed care plan and a participating provider shall require the provider to comply with the plan's requests for any information necessary for the plan to comply with the data reporting requirements of the law.

Accreditation of managed care plans

Beginning January 1, 1999, the commissioner shall contract with one or more certified vendors of the consumer assessment health plan survey to conduct a survey of all plans actively offering managed care plans in the state. The purpose of the survey is to provide plans with an opportunity to learn whether any deficiencies exist or any improvements are required; provided that the information collected shall be kept confidential in the first year, and thereafter shall be available to the public.

All plans in the state must either be accredited by January 1, 2000 or they must submit a plan to the commissioner to achieve national accreditation status within five years.